The Blue Shield Concept

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HISTORICALLY, the medical profession has been responsible for the health care of the people of our country. Physicians, as guardians of the public health, have been accepted in that role by the people.

In the past few decades the maintenance of this position has become more difficult. Medical science has made rapid strides. Improved drugs and techniques are available. The death rate has constantly declined. And, simultaneously, these advances have brought increased costs.

The "horse and buggy" doctor is no more.

Blue Shield came into this picture in a small way in about 1917, when county medical bureaus were set up in some states to provide a prepayment service for the public. Regular payments during periods of well-being created a pool of funds for the costs of illness when it struck.

In 1938 the first step toward a statewide plan of this type was taken in California with the formation of California Physicians' Service. This plan was based on the established need of the public to recognize medical costs as a part of their total expenses —to pay while well for services to be provided when ill. In short, to budget the costs of medical care.

C.P.S. undertook this program knowing nothing of whether it would or could work. In empirical fashion it took up and dropped numerous proposals, established clinical and actuarial figures never before available, and it made mistakes. Above all, it established the medical profession as the sole body which considered the health care of the people of primary importance.

The medical profession undertook, in one step, to let the people know that it stood ready to assist them in their economic as well as their clinical ills and that this guarantee of service was to last forever.

Despite difficulties it encountered because there were no preexisting formulas, C.P.S. stayed doggedly with its original premises: The plan must be nonprofit. There must be free choice of physicians by the patient. There must be free choice of hospitals. There must be community—grass-roots—management and policy making. There must be a guarantee that the patient would receive the care needed to restore his health, rather than an agreement to pay out *X* dollars per injury or illness. There must be financial responsibility, even if the participating physicians received only a fraction of their normal fees for services.

The rate of payment to physician members was based on units rather than dollars—and the value of a unit could not be established until the number of dollars available was known. As a result, in some months the physician members received only 25 per cent or 50 per cent or 70 per cent of what were considered fair and equitable fees. In one special project during World War II the unit rate at one time was 0. All the services provided by physicians during a full month at that time went completely unpaid for.

Fortunately, there were medical leaders in a number of counties of the state who served as rallying points for C.P.S. By their own personality and integrity they kept their colleagues informed and willing, regardless of fees, to prove that medicine was still interested in the welfare of the patient first.

With the passage of time, and with the benefit of a constantly expanding field of knowledge, C.P.S. began to come into its own. Similar plans, based on the same fundamental premises, sprang up in other states. Ultimately, a national organization of Blue Shield plans was formed. It has grown to a great size today and is nationally famous for providing its members with factual and technical information, for settling disturbing problems encountered when the patient moves from one jurisdiction to another and, most important of all, for supplying the means by which employed groups with places of employment in more than one state may secure coverage wherever they are situated.

Basically, Blue Shield plans are statewide in nature. However, through a federation of such local plans, they become nationwide and achieve the stature needed to provide services for nationwide employee groups.

More than that, by serving on a nonprofit basis they are able to set the standards by which all prepayment medical care plans must operate. Other carriers are faced with medicine's own answer to the health care needs of the people; they must either get out of the picture or get into it as competitors. And, as always, competition is good for people. Here it provides medically established fields of service, medically acceptable methods of payment

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for services and, most important, standards which must be met if both the people and the physicians are to be happy enough to continue their support.

Fortunately, with the growth of Blue Shield plans throughout the country, there has come a greater understanding by people of what Blue Shield really represents. It is more than an insurance carrier. It is more than a prepayment plan sponsored by physicians rather than by laymen.

It is, in short, a philosophy of service to people. It is the medical profession's acceptance of responsibility to people and its guarantee that that responsibility will be carried out. It is the profession's recognition that the patient has economic as well as physical ills. It is the profession's assurance that *all* the problems of the patient, both physical and economic, will be recognized and cared for.

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